

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8554**
Registrar's No. _____

Registration District No. **968**

Primary Registration District No. **6208**

1. PLACE OF DEATH:

(a) County **Webster**
(b) City or town **Union township**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **X** (Specify whether)
In this community **+** years, months or days

3. (a) PRINT FULL NAME

Ellen Nadine Rader

3. (b) If veteran, name war **X**

3. (c) Social Security No. **X**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **X** years

7. Birth date of deceased **January 22, 1940**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
70	70	14	X hr. X min.

9. Birthplace **Webster**
(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name **Arthur Rader**
13. Birthplace **Webster Co. Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Freda Tillman**
15. Birthplace **Webster Co. Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Arthur Rader**

(b) Address **Conway mo**

17. (a) **Burial** (b) Date thereof **Feb. 6, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rader**

18. (a) Signature of funeral director **Arthur Rader**

(b) Address **Conway mo**

19. (a) **Mar 9-40** (b) **Mrs W F Schlecht**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Webster**
(c) City or town **Union township**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? **X** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **5**
year **1940** hour **5** minute **PM**

21. I hereby certify that I attended the deceased from **1-22**, 19**40** to **2-5**, 19**40**
that I last saw **her** alive on **2-6**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **congenital heart condition**
pericardial effusion
Due to **to clear**

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
(e) Means of injury _____

23. Signature **W Hinchey** (M. D. or other) **1**
Address **Conway mo** Date signed **2-6-40**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

